Kansas Department for Children and Families

Application for Benefits for the Elderly and Persons with Disabilities

This is your application for the programs and services we offer. Answer all of the questions to the best of your ability. If English is not your primary language, an interpreter will be provided at no cost to you. You are subject to severe penalties for any false or misleading information you supply on this application.

Agency Use Only
Date Received: _____
Date Interviewed: _____
_____ Initial _____ Review
Valid Thru: _____
Worker: _____
Case Number(s): _____

This form provides us with the information we need to determine eligibility for you and your family. The following are the programs and services you can apply for with this form:

Medical Assistance: Medical assistance programs provide medical coverage for the elderly and people with disabilities. Medical coverage may help pay medical bills, doctor's visits and medicine. To apply for medical, fill out all of the sections where you see the medical bag.

Food Assistance: Food Assistance is electronic benefits you can use to buy food. If you need help buying food fill out all of the sections where you see the shopping cart. You may be eligible to receive food assistance within 7 days.

General Assistance: General Assistance (GA) provides access to medical benefits on a time limited basis for disabled adults without children. The program serves those who do not qualify for other state or federal programs. To apply for General Assistance, fill out all of the sections where you see the "G" symbol.

Follow These Steps to Apply

- Complete this form or go online at www.dcf.ks.gov to apply. If you need help or have questions call 1-888-369-4777.
- Read the questions carefully and answer honestly. If you are applying for someone else, please answer the questions for that person.
- Be sure to sign and date this form. Your application is not complete until it is signed.
- If you can't complete the application right now, give your name, address, and signature on Page 1 and return the form. We need all of the information to see if you can get the help you request.
- Return this form as soon as possible. If you are eligible, some benefits start from the date a signed application is received in our office.
- Mail, fax or bring this form to your local DCF office. It may take 30 to 45 days before your application is processed.
- If an interview is required, we will contact you.
- A list of items we may need from you is on the last page of this form. Please tear off and keep for your records.

Other services: DCF also offers the services listed below. If you would like more information or to apply, please check the appropriate box.

☐ **Child Support Services** - To enforce child support orders and to help assure that children have access to financial support and health care.

☐ **Vocational Rehabilitation** - To help persons with disabilities become employed.

Return this form to:

A. Help Us Decide if You Can Get Food/Medical Assistance Faster

If you have little or no money, we may be able to get you food assistance within 7 days. If you are pregnant, we may be able to get you a medical card within 10 days. Complete this section to help us decide if you can get benefits faster.

Agency Use Only

Expedited FS?
☐ No ☐ Yes

Expedited Medical?
☐ No ☐ Yes

1. Is anyone in your household pregnant?
   ☐ No ☐ Yes If yes, list name and due date: _____

2. Will your household's gross income for the month be less than $150?
   ☐ No ☐ Yes
3. Does your household have less than $100 in cash, checking, and savings?
   ☐ No ☐ Yes
4. Is anyone in your household a migrant or seasonal farm worker?
   ☐ No ☐ Yes
5. Enter your current rent/mortgage amount ..... $_____
6. Do you pay for heating or cooling costs? ☐ No ☐ Yes
   If no, enter your current monthly utilities. In none enter zero..... $_____
7. Enter your household's gross income expected this month..... $_____
8. Enter your household's total money in cash, checking and savings..... $_____

Agency Use Only

Rent/Mortgage $_____

SUA/Actual + $_____

TOTAL = $_____

Expected Income $_____

Cash/Check/ Savings + $_____

TOTAL = $_____

Are the household's shelter expenses more than the expected income and resources?
☐ No ☐ Yes

B. Tell Us About Yourself and the People in Your Home

For which program(s) are you applying? Check all that apply.

☐ Medical Assistance ☐ Food Assistance ☐ General Assistance

Tell us if you need any of the following medical programs:

☐ Working Healthy ☐ Home and Community Based Services

☐ Nursing Facility ☐ Help with Medicare Costs

Provide the following information and sign this section of the application.

Name: _____ **Signature:** _____
First Name, Middle Initial, Last Name

Street Address: _____ City: _____ Zip: _____

Mailing Address: _____ City: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____ E-mail: _____

Are You: ☐ Single ☐ Married(Includes Common Law) ☐ Divorced ☐ Separated ☐ Widowed ☐ Unmarried Couple

If widowed or divorced, list name(s) of your former spouse(s): _____

B. Tell Us About Yourself and the People in Your Home (continued)

You must tell us about everyone living in your home. List anyone who lives with you even if they do not need assistance. Also list anyone who usually lives with you, but is away right now, but will return soon.

Social Security numbers and citizenship/immigration status must be provided for all persons for whom you are **requesting food and/or medical assistance**. If you request food and/or medical assistance for a household member who does not meet citizenship/immigration status that person cannot get benefits while the remaining household members who DO meet citizenship/immigration status may quality for benefits. If you choose not to request food and/or medical assistance for certain persons in your household, you do not need to answer questions about Social Security numbers or citizenship/immigration status. However, you may be required to provide financial information for these persons as it may be needed to determine eligibility and amount of benefits for persons who you are applying for.

You may choose not to list your race or ethnic heritage and it will not be used against you. We only ask this information for Federal reporting purposes. Answers will in no way affect eligibility or benefits. If applying for food assistance only, identifying the sex of the household members is not required.

Important information about Social Security numbers- A Social Security number is required for each person for whom food and/or medical assistance is requested. If you are not applying for food and/or medical assistance for certain person(s) in your household, you are not required to provide a Social Security number for that person. For each person for whom you are requesting food and/or medical assistance, if you, without good cause, fail to provide or apply for a Social Security number that person will not be able to get benefits.

Use additional information sections on page 14 or 15 if there are more than 3 persons in your household.

First Name, MI, Last Name	Relation to You	Are you applying for this person?	Sex M/F	Birth Date	Social Security Number (optional for child care)	Race/Ethnic Group (optional) **Use codes below** Race | Ethnicity		City and State of Birth/ Citizenship Status (List place of birth and check one box.)
	Self	☐ No ☐ Yes	☐ M ☐ F					City and State of Birth _____ ☐ Citizen ☐ Noncitizen
		☐ No ☐ Yes	☐ M ☐ F					City and State of Birth _____ ☐ Citizen ☐ Noncitizen
		☐ No ☐ Yes	☐ M ☐ F					City and State of Birth _____ ☐ Citizen ☐ Noncitizen

Race/Ethnicity Codes: The following codes are for federal reporting purposes and will not affect your benefits.

Race (choose as many as apply): A = American Indian/Alaskan Native B = Black/African American P = Native Hawaiian/Pacific Islander S = Asian W = White

Ethnicity (choose only one): H = Hispanic or Latino N = Not Hispanic/Latino

Agency Use Only

B. Tell Us About Yourself and the People in Your Home (continued)

1. Which of the following best describes your current living situation?

   ☐ own home ☐ renting ☐ living with someone else ☐ assisted living ☐ hospital - date admitted: _____

   ☐ nursing facility or other institution - date admitted: _____ ☐ other living situation: _____

   Name of nursing facility, hospital or other institution: _____

2. Have you ever been in a hospital or nursing facility for more than 30 days in a row?

   ☐ No ☐ Yes If yes, when? (month/day/year through month/day/year): _____

3. Are you a Veteran?

   ☐ No ☐ Yes If yes, list VA claim number: _____

4. Have you ever been married to a veteran?

   ☐ No ☐ Yes If yes, list name of veteran spouse: _____

5. Is anyone getting, or has anyone received medical, food assistance, or tribal commodities in this or another state?

   ☐ No ☐ Yes If yes, complete the following:

   What benefits: _____ State: _____ Month/Year: _____

6. Are any household members living outside the home?

   ☐ No ☐ Yes If yes, list name(s): _____

   Why are they living outside the home? _____

   Date expected to return: _____

7. Do any household members get benefits from the Food Distribution Program on Indian Reservations?

   If yes, where? _____

8. Is anyone in your household fleeing from felony prosecution or jail? If yes, list name(s): _____

9. Is anyone in your household in violation of probation or parole? If yes, list name(s): _____

The following questions are required by federal law for purposes of the food assistance program only. If you answer yes to any of the questions, make sure to list the name(s) of the persons involved.

10. Has anyone in your household been convicted of trading food assistance benefits for drugs after September 22, 1996?

    ☐ No ☐ Yes If yes, list name(s): _____

11. Has anyone in your household been convicted of buying or selling food assistance benefits over $500 after September 22, 1996?

    ☐ No ☐ Yes If yes, list name(s): _____

12. Has anyone in your household been convicted of fraudulently getting duplicate food assistance benefits in any state after September 22, 1996?

    ☐ No ☐ Yes If yes, list name(s): _____

13. Has anyone in your household been convicted of trading food assistance benefits for guns, ammunitions, or explosives after September 22, 1996?

    ☐ No ☐ Yes If yes, list name(s): _____

C. Tell Us How You Want Us To Communicate With You

We provide interpreter and translation services. Complete this section to help us meet your needs. Does anyone in your household have a primary language other than English? ☐ No ☐ Yes

If yes, write in the names of spoken and/or written language on the next page. Also include other communication needs such as braille, relay, signed English, TDD/TTY, Large Print, Voice Synthesizer Program, etc.

C. Tell Us How You Want Us To Communicate With You (continued)

Name	Spoken Language	Written Language	Other Needs

D. Tell Us About Your Medical Bills and Insurance

We need to know about your medical bills and any insurance coverage that you have to correctly determine your eligibility. Answer the following questions:

1. Do you have any unpaid medical bills from the past three months?

☐ No ☐ Yes If yes, list: _____

_____

2. Do you want help with medical bills (including Medicare premiums) from the past three months? ☐ No ☐ Yes
3. Does anyone in your household have Medicare? ☐ No ☐ Yes If yes, complete the information below.

Refer to your Medicare Card:

Person Covered	Medicare Claim #	Type of Coverage check box(es)	Effective Date	Premium Amount	Plan Name
		Part A ☐			
		Part B ☐			
		Part D ☐			
		Part A ☐			
		Part B ☐			
		Part D ☐			
		Part A ☐			
		Part B ☐			
		Part D ☐			

4. Is anyone in your household covered by other health insurance? ☐ No ☐ Yes If yes, complete the following: (Attach copies of your insurance cards - copy both sides.)

Person Covered	Name of Insurance Company	Type of Coverage (Hospital, Med, RX, Other)	List Monthly Premium Amount	Effective Date	Policy/Claim No.

E. Who Eats with You

Food assistance households are based on persons who live together, and who buy and cook food together. Do you (or will you after approval) buy and cook food separately from other people in your home? ☐ No ☐ Yes ☐ Live Alone

If yes, please list their names and relationship to you: _____

_____

F. Tell Us About Students in Your Home

Special rules apply to students. Complete this information to help us decide if these rules apply to your household. Is anyone in your home a student in high school, college, or vocational-technical school? ☐ No ☐ Yes If yes, complete the following:

Student Name	Grade	Name of School	PT - Part Time / FT- Full Time

G. Tell Us if You Want to Appoint Someone to Help with Your Case

You can name another person to help you get benefits. This person can help fill out the application, answer questions for you, and use the Vision card or Medical card for you. We will be able to share information with this person. The person can be a relative, neighbor, friend, durable power of attorney or other person you trust.

1. If you want to have someone help you, complete the information about this person below:

Name:_____ Telephone Number: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____ Email Address: _____

What is this person's relationship to you (e.g., child, friend, attorney, etc.)? _____

I appoint the above named person to be my representative to apply and manage my benefits. This person will receive copies of any letters about my case and will be responsible for completing review forms and reporting changes:

Signature: _____ Date: _____

Witness: _____ Date: _____

Witness: _____ Date: _____

2. If you are approved for food assistance, you will get a Vision Card to access your benefits. Do you want the person named above to have access to your benefits? ☐ No ☐ Yes
   If no, do you want to choose someone else to help get your food assistance benefits? ☐ No ☐ Yes
   If yes, complete the following information for this person. This person will be your authorized representative. We will be able to share information with this person and this person can have access to your food assistance benefits.

Name:_____ Telephone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

H. Tell Us if You Are Disabled

We need to know if any persons in your household have a disability. Note: Personal Health Information disclosed here will only be used to determine your disability status and will not be shared with others. Complete the following:

1. Does anyone in your household have a disability? ☐ No ☐ Yes If yes, who: _____
   If No, proceed to Section I. Note: If more than one person has a disability, answer questions for the second person on page 13.
2. Does this person get Social Security disability benefits? ☐ No **Complete questions 3 through 6.**
   ☐ Yes **Proceed to Section I**
3. Please describe the disability: _____

H. Tell Us if You are Disabled (continued)

4. Do you think the disability will last more than 12 months? ☐ No ☐ Yes
5. Do you think the disability will result in death? ☐ No ☐ Yes
6. Has this person ever applied for Social Security benefits? ☐ No ☐ Yes If yes, complete the following:
   a. Was the application denied? ☐ No ☐ Yes If yes, when: _____
   b. Is the denial under appeal? ☐ No ☐ Yes If yes, status: _____
   c. Has the existing condition become worse since the Social Security denial? ☐ No ☐ Yes If yes, explain: _____
   d. Do you have a new disability or condition that Social Security did not look at? ☐ No ☐ Yes If yes, briefly describe the disability: _____
   e. Is an attorney or someone else helping you with the Social Security application for disability benefits? ☐ No ☐ Yes
   If yes, list name of the person and organization: _____ Phone Number: _____

I. Tell Us About Your Resources

We need to know about your resources to decide if you can get benefits. If needed, use page 14 or 15 to list more information.

1. Does anyone in your household own or have their name on any resources?
   ☐ No ☐ Yes If yes, complete the following. Mark no or yes on each item below.

Type of Resource		Name(s) on Resources	Amount or Value	Where is Resource Held? (Name of Bank, Credit Union or Company)	Account No.
Cash	☐ No ☐ Yes				
Checking Account	☐ No ☐ Yes				
Savings/CD	☐ No ☐ Yes				
IRA	☐ No ☐ Yes				
Nursing Facility Accounts	☐ No ☐ Yes				
Stocks and Bonds	☐ No ☐ Yes				
Funeral or Burial Plans	☐ No ☐ Yes				
Burial Plots	☐ No ☐ Yes				
Other: _____					
Other: _____					
Do you have a vehicle? ☐ No ☐ Yes Registered in Kansas? ☐ No ☐ Yes	Year: _____ Make: _____ Model: _____ Owner: _____ Year: _____ Make: _____ Model: _____ Owner: _____				

I. Tell Us About Your Resources (continued)

2. Does anyone in your home have life insurance? ☐ No ☐ Yes If yes, complete the following:
(Include copies of all policies.)

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value

3. Does anyone in your household own a home? ☐ No ☐ Yes If yes, complete the following:

Owners:_____Location: _____

Date Purchased:_____Value: _____Amount Owed:_____

Who lives in this home?_____

If the owner does not live there, explain why: _____

If the owner does not live there, does the owner intend to return home? ☐ No ☐ Yes If yes, when? _____

_____

4. Does anyone in your household own other real estate (including buildings, lots, farm ground, second homes)?

☐ No ☐ Yes If yes, complete the following:

Describe Property: _____

Location: _____

Owner(s): _____Value: _____Amount Owed:_____

5. Does anyone in your household have a life estate or life interest in any property? ☐ No ☐ Yes

If yes, complete the following:

Describe Property: _____

Location: _____Owner(s): _____

List date life estate created: _____Value of Property: _____

6. Does anyone in your household have a trust? ☐ No ☐ Yes If yes, list type, owners, purpose and amount below:

_____

_____

_____

7. Does anyone in your household have an annuity or other similar investment, including those issued as part of a retirement package? ☐ No ☐ Yes If yes, complete the following:

Owner(s): _____ Value: _____

Company: _____

Note: For Long Term Care assistance, the State of Kansas must be named as the beneficiary of any annuity you own which was purchased on or after February 8, 2006. More information will be given to you about this process. You agree to make this assignment when you sign the application.

8. Does anyone owe you money through a promissory note or other loans? ☐ No ☐ Yes If yes, explain:

_____

I. Tell Us About Your Resources (continued)

9. Does anyone in your household have other assets (such as an R.V., trailers, boats, livestock, oil rights, machinery, etc.)?

☐ No ☐ Yes If yes, complete the following. If needed, use page 14 or 15 to list more information.

a. Describe Asset: _____

Owner(s): _____ Value: _____

b. Describe Asset: _____

Owner(s): _____ Value: _____

10. Have you or your spouse taken a loan against any property in the last five years, including a second mortgage?

☐ No ☐ Yes

11. Have you or your spouse ever waived rights to an inheritance or will?

☐ No ☐ Yes

12. Have you or your spouse ever worked with an attorney for Estate Planning purposes?

☐ No ☐ Yes If yes, complete the following: Name of Attorney: _____ Date: _____

13. Have you or your spouse changed ownership, sold or given away any asset in the last five years (such as cash, CD's, stock, house, land, or any other assets)?

☐ No ☐ Yes If yes, complete the following:

Date Ownership Changed	Type of Asset	Value	Given/Sold To	Purpose

J. Tell Us About Your Earned Income

We need to know about all income from jobs, self-employment, contract labor, etc. Is anyone in your household self-employed or working at a job? ☐ No ☐ Yes If yes, complete the information below for all jobs. Self-employment includes earnings from odd jobs, child care, lawn mowing, snow removal, cosmetic sales, etc. If needed, use page 14 or 15 to list more information.

Name	Employers Name, Phone & Address (if self-employed, list type of business)	Salary or Hourly Wage	Tips or Commission	Weekly Hours Worked	How often do you get paid?	Day of the week paid

J. Tell Us About Your Earned Income (continued)

Do you have special expenses related to your disability that help you work? (Examples include service dogs, attendant care, specialized transportation for work, etc.) ☐ No ☐ Yes If yes, complete the following:

Type of Expense	Amount of Expense	How Often Paid?

Has anyone in your household lost or quit a job in the last 60 days? ☐ No ☐ Yes If yes, complete the following:

Name: _____ Employer: _____

Last Work Day: _____ Last Pay: $_____ Date: _____

Reason: _____

K. Tell Us About Your Other Income

We also need to know about all other income in your household to decide if you can get benefits.
Complete the following chart. Mark no or yes on each item below. If needed, use page 14 or 15 to list more information.

Type/Source of Income		Name of Person Who Receives This	Amount Received (before deductions)	How Often Received	Claim No.
Social Security Benefits	☐ No ☐ Yes	1.			
	☐ No ☐ Yes	2.			
	☐ No ☐ Yes	3.			
Supplemental Security Income (SSI)	☐ No ☐ Yes	1.			
	☐ No ☐ Yes	2.			
Veteran's Benefits	☐ No ☐ Yes				
Railroad Retirement	☐ No ☐ Yes				
Trust Payments	☐ No ☐ Yes				
Annuity Payments	☐ No ☐ Yes				
Other Retirement or Pension. Source: _____	☐ No ☐ Yes				
Worker's Compensation/ Unemployment	☐ No ☐ Yes				
Oil Royalties/ Mineral Rights/ Tribal Payments	☐ No ☐ Yes				
Contract Sale/ Rental Income	☐ No ☐ Yes				
Child Support	☐ No ☐ Yes				
Other Income Source 1:_____	☐ No ☐ Yes				
Source 2:_____	☐ No ☐ Yes				

Has anyone applied for other income or benefits? ☐ No ☐ Yes

If yes, list who and what income or benefits: _____

L. Tell Us About Your Household Expenses

To help us decide the correct amount of food assistance benefits, tell us about your shelter and other expenses.

Type of Expense	Amount	Who Pays?
Do you rent your home? ☐ No ☐ Yes If renting, list landlord's name, address and phone: _____ _____		
Do you own or are you buying your home? ☐ No ☐ Yes		
What is the amount of your monthly rent or house payment?	$	
If renting, is this subsidized housing, Section 8, HUD, other? ☐ No ☐ Yes		
If yes, tell us the amount you are obligated to pay each month	$	
Do you pay property taxes not included in house payment? ☐ No ☐ Yes	$	
Do you pay homeowner's insurance not included in house payment? ☐ No ☐ Yes	$	
Do you pay child or dependent care? ☐ No ☐ Yes	$	
Do you pay child support? ☐ No ☐ Yes List amount paid and court order number for each child: _____	$	
If you are 60 or older, or disabled, do you have any medical expenses? ☐ No ☐ Yes Include health insurance and Medicare Premiums. Use page 13 to list more information.	$	

Do you have any utility expenses? ☐ No ☐ Yes

Do you have a heating or cooling expense? ☐ No ☐ Yes

If no, check the following utilities you are responsible to pay:

☐ Water ☐ Sewer ☐ Trash ☐ Telephone ☐ Electricity/gas for cooking or lights ☐ Other _____ ☐ None

Have you or anyone at your current address received Low Income Energy Assistance (LIEAP)? ☐ No ☐ Yes

If yes when: _____

Does any one help you pay any of the above household expenses? ☐ No ☐ Yes

If yes, what expenses do you get help with? _____How much do they pay? _____

M. Choose Your Health Plan

If approved for medical assistance, your services will be provided by KanCare. There are 3 KanCare health plans to choose from. Please review the *Extra Services Highlights* and choose your plan. If you do not choose, a plan will be assigned for you. You will have at least 45 days to change your plan. You will receive a packet of information about your plan. Check the box next to your choice.

☐ Amerigroup ☐ Sunflower State Health Plan ☐ UnitedHealthcare

Please Read this Information Before Signing Page 13

Rights, Responsibilities, and Penalties

- I have read and understand my rights and responsibilities listed on the tear off page at the end of this form.
- I understand the questions on this application form.
- I understand the penalties for hiding information (penalties are shown on the tear off page at the end of this form).
- I understand the penalties for giving false information (penalties are shown on the tear off page at the end of this form).

Citizenship Status

- Signing this form means that I agree everyone living in my home who is asking for assistance is a U.S. citizen or is in legal immigration status. I understand this requirement does not apply to persons asking for Emergency Medical Assistance (SOBRA Program).

Changes You Must Report

- I agree to report changes such as changes in my address, income changes, and changes in individuals who live in my home.
- I understand my worker will send me a notice about the changes I am required to report.
- I will let my worker know of changes that might affect my eligibility or benefit level.

We Will Verify the Information You Give Us

- I understand you will verify the information I provide on this application form.
- I understand you may contact other agencies such as federal, state, local officials, employers, medical providers, businesses, financial organizations, and child care providers to verify information.
- I understand you will use the information you verify and that it could affect my eligibility or benefit level.

Information about Social Security Numbers

- I understand that I have to provide or apply for a Social Security number for people in my household who are asking for assistance.
- I understand Department for Children and Families (DCF) and the Kansas Department of Health and Environment - Division of Health Care Finance (KDHE-DHCF) use Social Security numbers to operate. The numbers are used for computer matches with the Social Security Administration, banks, the Internal Revenue Service, and other organizations and agencies.

Information about Food Assistance

- I understand I must report and verify my household expenses or I will not get a deduction for them.
- I understand that I may not use food assistance benefits to buy non food items, such as alcohol or cigarettes, or to pay on credit accounts.

Information about Cooperation

- I agree that everyone applying for and receiving medical assistance and who claims to be disabled must cooperate with determining presumptive medical disability.

Information about Medical Assistance Coverage

- I understand the KDHE-DHCF is responsible for administering the medical assistance program.

Third Party Resources

- I understand that the Kansas Medical Assistance Program will only pay for services not covered by other insurance or other third parties.
- I am responsible for using and reporting all third party resources for everyone in my home who receives medical assistance. Examples of third party resources are health insurance coverage, a court settlement, medical support payments, a trust, or a conservatorship. These sources may be legally responsible for paying some of the medical expenses of a person.
- I understand that you may not pay for medical services if you believe a third party resource was not used first.
- I agree to help you go after all third party resources. The Medical Subrogation Unit goes after other parties for payment of medical services. I will help this unit pursue all third party resources.

Payments and Support

- If we are approved for medical assistance, we agree to let payments for medical services go directly to our physicians and other medical providers.
- If we are approved for medical assistance, we will turn over to the KDHE-DHCF any medical support payments we get.

Estate Recovery Provisions - The following DOES NOT apply to the Medicare Saving Programs.

- If anyone receives medical assistance after age 54 or while in an institution, I understand there may be a claim against the estate of the recipient or spouse to recover the medical expenditures made on their behalf.
- I understand you will tell all of our financial institution(s) and other investment companies about your pending claim on the estate.

Health Department Referral

I give my permission for my name and the names of those on my case, our address, telephone number, and eligibility status to be given to medical providers and local health departments so that they may give us information about services they provide. ☐ No ☐ Yes

Information about the Lifeline Telephone Program

- For cash (Temporary Assistance for Families) and food assistance, I agree that DCF may provide my name, address, and telephone number to telephone companies participating in the Lifeline data match. The Lifeline Program provides basic telephone service at a reduced rate.
- I understand that my information is confidential and will only be used by the participating telephone carriers to verify my eligibility for Lifeline telephone assistance.
- I understand that the Lifeline program is not mandatory and that I will have to apply for this service by contacting my local telephone company.
- I understand that not all telephone carriers participate in the Lifeline data match with DCF and that I may have to provide proof of my household income to my local telephone company for them to determine my Lifeline eligibility.

Permission to Release Information

My signature on this application authorizes employers, health care providers, financial institutions, insurance providers, benefit providers, and other persons or agencies with knowledge of my circumstances to release to the Kansas Department for Children and Families (DCF) and to the Kansas Department of Health and Environment - Division of Health Care Finance (KDHE-DHCF) any information, including confidential and health information, necessary to establish my eligibility for benefits or to administer any program for which I applied.

I authorize DCF and KDHE-DHCF to share medical information for administrative purposes with other agencies and contractors.

I understand all information provided on this application and all information provided to DCF or KDHE-DHCF staff on my behalf is protected by state and federal confidentiality laws.

This release is valid from the date of signature set out below and shall remain valid until revoked in writing by the undersigned. A copy of this authorization is as valid as the original.

I certify under penalty of perjury that my answers are correct and complete to the best of my knowledge. I understand that in addition to other penalties, it is illegal to obtain, attempt to obtain, or help any other person to obtain, by means of a willfully false statement or representation, or by impersonation, collusion, or other fraudulent device, assistance to which they or I am not entitled, and this shall constitute the crime of theft, as defined by K.S.A. 2011 Supp. 21-5801, which could be a felony offense punished by over 11 years imprisonment and fine of up to a $300,000.

Your Signature	**Date**
Your Spouse's Signature or another adult in your home (Not Required)	Date
Signature of First Witness (if "X" is used)	Date
Signature of Second Witness (if "X" is used)	Date
Signature of Court-Appointed Guardian/Conservator (if applicable)	Date
Signature of Medical Representative (if applicable)	Date

Kansas Voter Registration Information

This section will not affect the assistance or services that you can receive from DCF or KHDE-DHCF.

You can easily register to vote using this website: https://www.kdor.org/voterregistration/

Or, DCF can help you with the voter registration. Would you like our help in registering to vote?

☐ No ☐ Yes ☐ Already registered where I live now.

If you do not check any boxes, you will be considered to have decided not to register to vote at this time. This decision will remain confidential and will be used only for voter registration purposes. If you have additional questions or need to report a problem, you may contact your county elections officer, the Secretary of State's office, or call 1-800-262-VOTE(8683). If you do register to vote, information regarding the office where the application was submitted will remain confidential and be used only for voter registration purposes.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose you own political party or other political preference, you may file a complaint with the Kansas Secretary of State.

Use this space to write additional information.

Use this space to write additional information.

Kansas Department for Children and Families
Application for Benefits for the Elderly and Persons with Disabilities
Rights and Responsibilities - Read and Tear Off for Your Records

Processing times for your application are:

- within 30 days for food assistance;
- within 45 days for medical assistance;
- within 90 days for presumptive medical disability.

If you are eligible, benefits will start from the date a signed application is received in the DCF office. You may be able to get food assistance within 7 calendar days if you qualify. We will let you know if you qualify for this special processing.

The following information applies to all programs: 

Your Responsibilities:

You have a responsibility to:

- provide all information needed to determine your eligibility;
- report changes as required - we will tell you what must be reported (examples include someone leaving or moving into your house, change of income, selling property, moving into a nursing home, new address, etc.);
- use, and report to DCF, any resources that could help pay for your family's medical expenses (examples include insurance policies, money won through lawsuits, or medical support payments) (medical and cash assistance only);
- cooperate with Quality Assurance staff if your case is reviewed.

Your Rights:

You have a right to:

- have an interpreter provided at no cost if English is not your primary language;
- have information given to DCF kept confidential, unless directly related to the administration of DCF programs;
- withdraw your application at any time;
- request a fair hearing within 30 days for medical assistance, or within 90 days for food assistance if you disagree with the decision. For food assistance, you may request a fair hearing orally or in writing. Your case may be presented by a household member, or by a representative such as legal counsel, a relative, friend or other spokesperson;
- know that if you apply for food assistance benefits, your application may not be denied solely because benefits have been denied for other programs;
- have your benefits determined from the date this application is received by DCF;
- special considerations and confidential services, if you are in danger of domestic violence or sexual assault; and
- In accordance with Federal Law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food and Nutrition Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Bldg, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 720-5964 (voice or TDD). Write HHS, Director, Office of Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). USDA and HHS are equal opportunity providers and employers.

DCF Rights:

DCF has a right to:

- **use the information on this application, including the Social Security number (SSN) of each person in your home, to decide whether your household can get benefits. We will verify this information through computer matching programs. This information will also be used to make sure you are getting the correct amount of benefits.**
- **verify the alien status of applicant household members by submitting information from the application to the USCIS. The information received may affect the household's eligibility and amount of benefits;**
- **deny benefits to your household if you do not provide requested information;**
- **disclose the information on your application to other federal and state agencies for official examination, and to law enforcement officials for the purpose of arresting people who are running from the law.**
- **refer the information on this application to federal and state agencies, as well as private claims agencies, for claims collection if overpayments arise against your household;**
- **conduct a full investigation of your eligibility including contacting employers, banks, doctors, or by visiting your home;**
- **deny your application or prosecute you for fraud if you knowingly give us false information so you can receive assistance; and**
- **give information to the KDHE-DHCF to administer medical assistance.**

Fraud Penalties

A. Food Assistance - Any member of your household who intentionally breaks the following rules will be disqualified as stated below:

- **Do not lie or hide information to get benefits that your household should not get.**
- **Do not use, or have in your possession, Vision Cards that are not yours.**
- **Do not trade or sell Vision Cards.**

If you make false or misleading statements and you are found guilty of misrepresentation, you will not be able to get food assistance benefits:

- **for 10 years if your misrepresentation was about where you live or who you are in order to get duplicate benefits;**
- **for 1 year if your misrepresentation was about something other than identity or residence and it is your first program violation;**
- **for 2 years if your misrepresentation was about something other than identity or residence and its is your second program violation;**
- **ever again if your misrepresentation was about something other than identity or residence and it is your third program violation.**

Your food assistance eligibility will also be suspended for 2 years or permanently lost if you are convicted of buying or selling over $500 worth of benefits or if you use the benefits, or receive them, in a sale of controlled substances, firearms, ammunition or explosives. In all of these cases, the remainder of your food assistance household can get benefits if they are otherwise eligible, but the rest of the household will still be responsible for repaying the amount of any benefits overpayment that was received by the person disqualified.

Fraud Penalties (continued)

B. Medicaid - The Kansas Medicaid Fraud Control Act (K.S.A. 2011 Supp. 21-5925 through 21-5934 and K.S.A. 2011 Supp. 75-725 and 75-726) makes it a crime to make a false claim, statement or representation to the Medicaid program, or to trade a Medicaid number for money or other compensation, sign for services that are not received by the Medicaid recipient or sell or exchange for value goods purchased or provided under the Medicaid program. Such crimes could represent a felony offense punished by up to 34 months imprisonment and a fine of up to $100,000.

Interview

For food assistance, we require an interview as part of the application process. An interview is not required for medical but you may ask for one. You may request a telephone interview. If you miss the interview, you are responsible for scheduling another one.

- ☐ Your interview has been scheduled at: ->
- ☐ Your interview date and time is - Date: _____ Time: _____
- ☐ Please call for an interview appointment: _____
- ☐ Other: _____

Information Needed to Process Your Application

We may ask you to provide some or all of the following items. Please be ready to provide this information.

- Proof of where you live.
- Proof of age and identity.
- Proof of citizenship for those who want to receive benefits.
- Proof of non-citizen status for those who want to receive benefits.
- Dependent care bills and receipts.
- Proof of child support and/or alimony paid or received.
- Proof of income (pay stubs, earning statements, rental property/sales contracts, Government payments, Workers Compensation, pensions, and other).
- If self-employed, federal income tax returns, bookkeeping records, sales, and expenditure records.
- Life insurance and burial plans.
- Rent receipt/house payment (including insurance and property taxes).
- Proof of medical expenses such as medication, doctor bills and hospital bills.
- Health insurance cards and premium information.
- Bank statements for checking accounts, savings accounts, or stocks/bonds/mutual funds.
- Proof of trusts and annuities.
- Other: _____

We can help you get required verification. If you have any questions, or need help completing the application, call us toll free at 1-888-369-4777.

AD ASTRA PER ASPERA

Kansas

Department for Children and Families

Strong Families Make a Strong Kansas